Health Services Safety Investigations Body

Interim report

Creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning

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Mental health

Contents

A note of acknowledgement

We would like to thank the many people who contributed to this interim investigation report, including patients and staff in mental health inpatient settings and community mental healthcare teams. We would also like to thank the families and carers who spoke to us who have experienced the death of their loved ones whilst receiving mental health care.

The findings from this interim report can support improvements in taking a person-centred approach to patient safety risk assessment and safety planning for patients, families and staff.

Executive summary

Background

The aim of this report is to highlight the importance of staff in mental health inpatient units and community mental health services, taking a person-centred approach to patient safety assessment and safety planning. The findings of this report may also be relevant to other services that care for people with mental health problems.

People who require admission to an inpatient mental health unit are usually seriously unwell due to their mental health illness. People showing signs of heightened distress may demonstrate this in different ways including self-harming behaviours or thoughts of wanting to end their life. When a person is admitted to a mental health inpatient unit, staff carry out a risk assessment to understand whether they are likely to harm themselves and how best to keep them safe.

National guidance and safety recommendations have stated to stop using risk assessment tools that stratify an individual’s risk of suicide or self-harm as high, medium, or low risk. This is because traditional risk prediction measures have been

shown repeatedly, in studies, to be ineffective. Instead, biopsychosocial assessments have been identified to provide a more effective basis on which to understand risk factors to inform a patient's care. This is achieved by taking a holistic approach to understanding why someone has attempted to harm themselves and developing a safety plan with the patient (a practical plan to help the patient cope with distress, thoughts of suicide or self-harm).

Patient safety concerns relating to the continued use of risk stratification were identified during HSSIB's investigations on the theme of 'Mental health inpatient settings'.

Findings

- The use of risk assessment tools that provide a high, medium, or low risk score is no longer acceptable but continue to be used contrary to national guidelines for self-harm assessment.
- Patients who had expressed suicidal thinking, and their families and carers, said that they were not listened to when sharing their safety needs and their perceptions of risk were disregarded.
- Investigations into death by suicide and near misses often refer to questions and evidence associated with high, medium, and low risk stratification. These include, for example, coroners' investigations, local and regional serious incident investigations and public inquiries.
- Staff described a fear of being blamed if a risk assessment, including risk stratification, is not completed and a patient later comes to harm.
- Some digital patient record systems still require staff to categorise risk assessments as high, medium or low risk.
- Successful implementation of person-centred approaches to patient safety assessment and safety planning is dependent on many different factors including an organisations' leadership culture, the people that work within organisations and the emphasis on involving the patient and their families and carers, in the assessment and planning processes.
- Organisations have involved 'digital experts' in their electronic patient record system improvement projects. Examples of changes made include the removal of automated predictive elements of risk stratification, free-text boxes with an increased character limit for improved narrative, and added space for family/ carer views.

HSSIB notes the following safety actions, commenced in 2024 by NHS England

Safety action A/2024/002:

- NHS England, working with the National Collaborating Centre for Mental Health, is identifying 10 organisations to lead work to co-produce personalised approaches to safety planning in inpatient services. The learning will be shared through national learning networks. This is expected to be complete by March 2026.
- NHS England is producing national guidance on Safety Assessment and Safety Planning, specifically relating to person-centred safety assessment and planning, to support organisations in complying with the National Institute for Health and Care Excellence guidance 'Self-harm: assessment, management and preventing recurrence'. This is expected to be complete in April 2025.

HSSIB makes the following safety observations

Safety observation O/2024/030:

Organisations can improve patient safety by taking a person-centred approach to biopsychosocial assessments and safety planning and stop asking for evidence of risk assessment tools that stratify an individual's risk of suicide or self-harm as high, medium, or low risk.

Safety observation O/2024/031:

Organisations can improve patient safety by ensuring that a person centred approach to biopsychosocial assessment should be offered for all patients who have contact with mental health services, when a patient has an episode of self-harm or suicidal thinking, every time they make a transition between mental health services, and at key important times in the person's life. This is line with current guidance from the National Institute of Health and Care guidance.

Safety observation O/2024/032:

Organisations can improve patient safety by involving ‘digital experts’ in their electronic patient record system improvement projects. This will support any digital configuration and infrastructure changes required to record person-centred approaches to psychosocial assessments and safety planning.

Safety observation O/2024/033:

Organisations can improve patient safety by listening to and communicating with patients, their families and carers, about the safety and wellbeing of people who have self-harmed and/or are expressing suicidal thoughts. It is important that this involvement starts from the point of a patient’s admission through to their discharge from inpatient mental health wards and during follow up.

Introduction

In June 2023 the Secretary of State for Health and Social Care directed HSSIB to investigate four elements of mental health inpatient care:

- Learning from inpatient mental health deaths, and near misses, to improve patient safety.
- The provision of safe care during transition from children and young person (CYP) to adult, inpatient mental health services.
- Impact of out of area placements on the safety of mental health patients.
- Creating the conditions for staff to deliver safe and therapeutic care – workforce, relationships, environments.

The investigation terms of reference and approach can be found on the HSSIB website.

This interim report was produced in response to patient safety concerns relating to the use of risk stratification tools identified by these investigations.

Purpose of this interim report

This interim report highlights the importance of taking a person-centred approach to biopsychosocial assessments and safety planning for patients in mental health inpatient units and community mental health teams, and of stopping the use of risk assessment tools that stratify an individual's risk of suicide or self-harm as low, medium or high. The findings of this report may also be relevant to other services that care for people with mental health problems.

Background

People showing signs of heightened distress may demonstrate this in different ways such as self-cutting or other potentially damaging behavioural ways of trying to manage their increased stress. Other people in distress may become very isolated and withdraw and not interact. If people are seriously unwell they may rapidly enter a state of distress where they see no options other than serious self-harm or death to end their suffering.

Suicide prevention in mental health care has been dominated by efforts to predict risk of suicide in individual patients. However, studies have repeatedly shown that traditional risk prediction measures are ineffective (Hawton et al, 2022).

Self-harm, and particularly frequent repetition of self-harm, is strongly associated with suicide (Witt et al, 2018). Identifying the risk of a person going on to self-harm or die by suicide is challenging (Seyedsalehi and Fazel, 2024). Research evidence states that the immediate risk of suicide at the time of a patient's last contact with mental health services was judged by clinicians to be low or not present for the majority (82%) of patients who died by suicide (The National Confidential Inquiry into Suicide and Safety in Mental Health, 2024). There is clear evidence that risk assessment tools are not an effective basis on which to predict future suicidal behaviour and incidents of self-harm, and therefore should not be used to decide whether or not to make care and treatment available for an individual (Carter et al, 2017; The National Confidential Inquiry into Suicide and Safety in Mental Health, 2018).

The National Institute for Health and Care Excellence (NICE) (2022) guidance on 'Self-harm: assessment, management and preventing recurrence' refers specifically to risk assessment tools and scales. It states:

- 'Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

- Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.
- Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.
- Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged.
- Focus the assessment on the person's needs and how to support their immediate and long-term psychological and physical safety.
- Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.'

The above guidance should be read in conjunction with other NICE guidance on the treatment of coexisting mental health conditions as most inpatients have a mental health diagnosis which would need evidence based effective treatment to reduce risk of suicide and/or self-harm.

Biopsychosocial assessments take a holistic approach to understanding why someone has attempted to harm themselves, taking into account many factors (Lascelles et al, 2022). Factors will include their mental health diagnosis, their treatment and how they are responding to their treatment, as well historical life factors and experiences, more recent problems, social, psychological and physical problems. Assessment and care by all staff should therefore be based on a patient's needs, vulnerabilities, and safety instead of a generic risk assessment. The aim of the assessment is to gain a clear picture of the patient's strengths and their vulnerabilities in order to create a personalised care plan for any clinical interventions that might be needed, and a safety plan. The safety plan may include the recognition of warning signs, listing their coping strategies, sources of support for example involving family and friends and limiting access to self-harm methods to help alleviate a crisis. These assessments are reviewed and updated as needed during the patient's mental healthcare journey.

In the summer of 2022, the Chief Coroner wrote a focused piece on assessment of suicide risk in their newsletter to coroners. This suggested that coroners should carefully consider the quality of suicide risk assessments, particularly if risk stratification tools had been used.

On 21 October 2022, following the publication of the updated NICE guidance mentioned above, the National Clinical Director for Mental Health wrote to the Chief Medical Officers of all mental health trusts in England to highlight the importance of taking a person-centred approach to psychosocial assessments and safety planning.

The communication asked trusts to move away from risk assessment tools that stratify an individual's risk of suicide or self-harm. The aim of the letter was to support the culture and practice change required to move towards more person-centred approaches to safety planning for people with mental health needs. However, there was no national guidance for mental healthcare providers on how to do this. New NHS England guidance due to be completed in April 2025 will provide this.

In March 2023, the Healthcare Safety Investigation Branch (HSIB) published its report 'Care delivery within community mental health teams'. One of the report's findings stated:

'While national guidance says that a patient's risk of harm should not be stratified into categories such as high, medium or low, such stratification remains common in many trusts. This is because other methods of assessing and documenting risk are not available, and because staff fear being blamed if a patient comes to harm without a risk assessment, including risk stratification, having been completed.'

(Healthcare Safety Investigation Branch, 2023)

HSIB made a safety recommendation to NHS England that:

'NHS England works with appropriate stakeholders, including experts with appropriate experience, to create guidance on culture change. A quality improvement programme should also be developed to support practitioners in undertaking psychosocial assessments that are in line with guidance from the National Institute for Health and Care Excellence. Person-centred safety planning should be embedded within the process.'

(Healthcare Safety Investigation Branch, 2023)

On 1 June 2023, the National Clinical Lead for Psychological Professions wrote to their professional members (copied to the Health and Care Professions Council and the Professional Standards Authority) to draw attention to the need to fully implement the NICE guidance 'Self-harm: assessment, management and preventing recurrence'. Part of the Professional Standards Authority's role is to accredit voluntary registers of health and care roles that are not required by law to be registered with a statutory body. These are known as 'Accredited Registers', and they cover approximately 85,000 people working in mental health roles. Following the National Clinical Lead's letter, the PSA wrote to its Accredited Registers to highlight the importance of implementing the NICE guidance 'Self-harm: assessment, management and preventing recurrence'.

One of the key actions set out in the government’s suicide prevention strategy for England 2023 to 2028 (Department of Health and Social Care, 2023) was that NHS England would identify opportunities to improve the quality and culture of risk management and safety planning within mental health services. The position regarding risk assessments was included in NHS England guidance to improve the culture of care in mental health inpatient services (NHS England, 2024). In addition, the suicide prevention strategy for England 2023-2028 placed a new emphasis on families bereaved or affected by suicide. This aimed to improve information and support for families who are concerned about a relative who may be at risk of suicide and to better support those who have been bereaved by suicide.

In January 2024, the Labour party announced ‘reforms to improve suicide prevention and save lives’ including its intention to ‘specially train mental health professionals to support people who self-harm, as part of the party’s national mission to drive down rates of suicide’ (PolicyMogul, 2024).

Emergent findings

There is evidence that some mental healthcare providers have begun work to support the changes in culture and practice that are needed to move towards more person-centred approaches to safety planning for people with mental health needs. NHS England told the investigation that there is an opportunity to share “what good looks like” at a national level and hosted a webinar on ‘Risk Assessment and Formulation in Mental Health’ in July 2024. Three examples where organisations have moved towards more person-centred safety assessments were shared. The investigation was told that implementation of person-centred approaches depended on many different factors including organisations’ leadership culture and available resources. One organisation described that “changing the language from 'risk assessment' to 'safety assessment' has helped staff to move from traditional ways of working to new ways of working. This was done following service user feedback that the language of risk assessment itself can be stigmatising…” This finding was supported by other organisations and there was a consensus that the language of ‘safety assessment’ should be used. NHS England have adopted the use of safety assessment and safety planning.

People with lived experience told the investigation that it is important for them to be able to share the underlying causes of their distress that leads to their self-harm or have thoughts of ending their life. Having a focus on their overall wellbeing and “hopefulness” were felt to be really helpful conversations and felt more individual to them.

However, HSSIB’s current investigations on the theme of mental health have seen and heard evidence of the continued use of risk assessment tools and scales to stratify an individual’s risk of suicide or self-harm which are not in line with NICE guidance and should not be used. In addition, the investigation has heard about the use of risk stratification which includes language and categories associated with high, medium and low risk to predict future suicide or repetition of self-harm.

The investigation has been told by mental healthcare providers that one of the contributory factors for this is that investigations into death by suicide and near misses often refer to questions and evidence associated with risk assessment, including risk stratification. These include, for example, coroners' investigations, local and regional serious incident investigations and public inquiries. Staff described a real fear of being blamed if a patient comes to harm without a risk assessment, including risk stratification, having been completed.

The investigation has been told by patients who had expressed suicidal thoughts that they were not listened to when sharing their safety needs and their perceptions of risk were disregarded. Patients receiving inpatient mental health care told the investigation their self-harming was described by staff as “attention seeking”. One patient described their fear and subsequent reaction to being discharged from a mental health inpatient unit when they felt they were not ready. They said: “I was discharged anyway because I was told I was just attention seeking.” They went on to cause themselves substantial life-changing injuries hours after their discharge. As a current inpatient, they describe being more involved in discharge planning this time and that “it feels collaborative”.

Evidence supports that families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk (The National Confidential Inquiry into Suicide and Safety in Mental Health, 2018). Families and carers of people who have died by suicide told the investigation that their opinions on risks to their loved ones of self-harm and suicidal intent were not listened to. A father of a young adult who died said: “I threw myself on the floor and begged them not to discharge her …”. Another family member of a young person who died described that they “felt very estranged as her family … we had no voice in her care, decision making and her safety”. Another parent of a young person who died said: “we were concerned about her safety and wanted to be informed of incidents of self-harm and more involved in decisions about her care but instead we were black marked and treated as difficult people … they cut us out of her care”. Another family member described not being told of their child’s new patterns of self-harming behaviours and subsequently they fatally self-harmed after discharge.

Within the Department of Health and Social Care Guidance on information sharing and suicide prevention consensus statement (2021), it states: “We have heard from a number of families bereaved by suicide about their experiences with services, and issues of confidentiality have been a recurring theme. They have repeatedly raised concerns that practitioners can seem reluctant to take information from families and friends or give them information about a person’s suicide risk”. To help address those concerns, an updated consensus statement for information sharing and suicide prevention was published to reflect the current legal position including the implementation of the UK General Data Protection Regulation (Information Commissioner's Office, nd). This guidance supports staff to understand their responsibilities in how patient information is shared, and with whom. Further published guidance on information on shared decision making (NICE, 2021) and service user experience in adult mental health (NICE, 2011) is available.

The investigation is aware of tools that are based on person-centred psychosocial assessments. However, some of these tools often still result in a rating of high, medium or low risk. Additionally, the tools’ high, medium, or low risk scores are used to inform decisions about person’s care and treatment. NICE guidelines have made it clear that the practice of risk stratification should not happen and their guidance applies to all sectors that work with people who have self-harmed. Some organisations use tools that are defined as ‘needs stratification’ tools rather than clinical assessment tools. However, the investigation considers that such tools may contribute to the global language of risk stratified into categories such as high, medium or low risk.

The investigation was told by a subject matter advisor that “for people who have a severe mental illness, there should already be a lot known in their existing care plans about their individual strengths and vulnerabilities … asking patient’s the same questions over and over is traumatising and increases the risk of harms. In addition it may contribute to learned helplessness and loss of hope (because it demonstrates that people haven’t listened or even bothered to read about them and loss of hope is a key tipping point to deciding life is not worth living…”. In these cases a more flexible approach to understanding the patient’s safety assessment and safety plan will be required.

NICE guidance (2022) advises that, ‘If a person presents with frequent episodes of self-harm or if treatment has not been effective, carry out a multidisciplinary review with the person and those involved in their care and support, and others who may need to be involved, to agree a joint plan and approach’. A multidisciplinary review should enable staff to reconsider current care, finding the most suitable care approach for the person and therefore preventing further repeat self-harm.

The investigation was told by staff that the user interface of digital patient record systems made it difficult to undertake person-centred assessments because they required staff to enter a risk stratification of high, medium or low risk. In addition, the investigation was told that in some situations, this rating was then used to inform decisions about people's care needs. Digital systems have in the past been developed on the basis of risk stratification and some systems do not allow staff to continue a risk assessment without first categorising the patient's risk as high, medium or low.

The investigation spoke with mental healthcare providers that have moved towards more person-centred approaches to safety planning for people with mental health needs. They said that they have included 'digital experts' as part of their improvement projects. This has enabled them to make changes to their electronic patient record systems. Examples of changes made include the removal of predictive elements of risk stratification, free-text boxes with an increased character limit for improved narrative, and additional space to add family/carer views. The importance of involving experts and leadership in designing the digital solution was described as 'essential' to the success of moving away from global risk stratification.

Ongoing safety improvements

To support a set of culture of care standards for mental health inpatients, NHS England has established the Culture Change Improvement programme. Launched in January 2024, the programme will deliver six interventions within 60 providers of NHS-commissioned mental health, learning disability and autism inpatient services. This work is planned over the next 2 years, to be completed by March 2026. NHS England told the investigation that one of the Culture Change Improvement programme interventions focuses on moving away from risk stratification by supporting staff in the theoretical knowledge and practical understanding and use of co-produced, personalised approaches to safety planning.

In May and July 2024, HSSIB wrote to the Chief Coroner to highlight the importance of looking for a person-centred approach to psychosocial assessments and safety planning and to move away from asking for evidence of risk assessment tools that stratify an individual's risk of suicide or self-harm as low, medium or high.

In July 2024, NHS England announced that it would develop and publish national guidance on safety assessment and safety planning . The Risk Assessment and Management Guidance Advisory Group (RAMDAG) which was set up in July 2024,

aims to set out principles for person-centred assessment, risk formulation and safety planning. This guidance will build on work taking place to develop the culture of care in inpatient services, including the culture of care standards which set out the vision for a more relational approach to safety.

HSSIB notes the following safety actions, commenced in 2024 by NHS England

Safety action A/2024/002:

- NHS England, working with the National Collaborating Centre for Mental Health, is identifying 10 organisations to lead work to co-produce personalised approaches to safety planning in inpatient services. The learning will be shared through national learning networks. This is expected to be complete by March 2026.
- NHS England is producing national guidance on Safety Assessment and Safety Planning, specifically relating to person-centred safety assessment and planning, to support organisations in complying with the National Institute for Health and Care Excellence guidance ‘Self-harm: assessment, management and preventing recurrence’. This is expected to be complete in April 2025.

To support existing reports and national guidance, HSSIB has made the following safety observations.

HSSIB makes the following safety observations

Safety observation O/2024/030:

Organisations can improve patient safety by taking a person-centred approach to biopsychosocial assessments and safety planning and stop asking for evidence of risk assessment tools that stratify an individual’s risk of suicide or self-harm as high, medium, or low risk.

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Next steps

The HSSIB investigation will continue to explore responsibility and accountability in relation to safety assessment and safety planning and how the guidance is supported in its national implementation and adoption. Additional findings and safety learning will be presented in the final investigation report. If you would like to share any experience or have further information that may be relevant, please contact enquiries@hssib.org.uk.

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